TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
PAIN & RECOVERY CLINIC

Respondent Name
AMERICAN ZURICH INSURANCE CO

MFDR Tracking Number
M4-17-2546-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
April 26, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our facility has been having difficulties with the above carrier in processing these authorized services which were denied for fee schedule adjustment."

Amount in Dispute: $1,062.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "...the carrier asserts that is has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF DISPUTED SERVICE(S)

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
January 20, 2017 and January 25, 2017	97799-CP-CA	$1,062.50	$1,062.50

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the sets out the fee guidelines for the workers' compensation specific services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers compensation jurisdictional fee schedule adjustment

Issue(s)

1. What is the applicable rule for determining reimbursement for the disputed services?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor seeks additional reimbursement for CPT Code 97799-CP-CA rendered on January 20, 2017 and January 25, 2017. The insurance carrier reimbursed the requestor for 1 unit at $125.00 for each date of service, for a total payment of $250.00. The requestor seeks additional reimbursement for 3 units for date of service January 20, 2017 and 5.5 units for date of service January 25, 2017.

   The insurance carrier denied the disputed services with claim adjustment reason code "P12 – Workers compensation jurisdictional fee schedule adjustment." The Division finds that the insurance carrier's denial reason is not supported and therefore will reviewed the disputed services per applicable Division rules and fee guidelines

   A review of the CMS-1500s and medical documentation for date of service January 20, 2017 finds that the requestor billed for 4 hours of CPT code 97799-CP-CA and 6.5 hours for date of service January 25, 2017.

   28 Texas Administrative Code §134.204(h)(1)(A) states in pertinent part, "The following shall be applied to Return To Work Rehabilitation Programs for billing and reimbursement of Work Conditioning/General Occupational Rehabilitation Programs, Work Hardening/Comprehensive Occupational Rehabilitation Programs, Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs, and Outpatient Medical Rehabilitation Programs. To qualify as a Division Return to Work Rehabilitation Program, a program should meet the specific program standards for the program as listed in the most recent Commission on Accreditation of Rehabilitation Facilities (CARF) Medical Rehabilitation Standards Manual, which includes active participation in recovery and return to work planning by the injured employee, employer and payor or carrier. (A) If the program is CARF accredited, modifier "CA" shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100 percent of the MAR..."

   Review of the submitted documentation finds that the requestor billed CPT Code 97799-CP and appended modifier -CA to identify that the chronic pain management program is CARF accredited, as a result, reimbursement is calculated per 28 Texas Administrative Code §134.204 (h). Reimbursement for the CARF accredited programs is calculated at 100% of the MAR for each date of service.

   28 Texas Administrative Code §134.204(h) (5) states, "The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs. (A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier. (B) Reimbursement shall be $125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes." The calculation of the Maximum Allowable Reimbursement (MAR) is found below:

Date of Service	Submitted Code	Submitted Charges	Units	MAR	Paid Amount	Amount Due
January 20, 2017	97799-CP-CA	$500.00	4	$125 x 4 = $500.00	$125.00	$375.00
January 25, 2017	97799-CP-CA	$812.50	6.5	$125 x 6.5 = $812.50	$125.00	$687.50
TOTAL						$1,062.50

2. Review of the submitted documentation finds that the requestor is entitled to additional reimbursement in the amount of $1,062.50 for CPT Code 97799-CP-CA rendered on January 20, 2017 and January 25, 2017. As a result, this amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,062.50.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,062.50 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		May 26, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.